

MUTUAL OF OMAHA INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE
BENEFIT PLANS A, B, C, D, F, G AND M

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2010 Including Revisions Effective January 1, 2020

This chart show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plans A and B and either D or G. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F and High Deductible F¹. Some plans may not be available in your state.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants									Medicare first eligible before 2020 only		
	PLAN A*	PLAN B*	PLAN D*	PLAN G*	G ¹	PLAN K	PLAN L	PLAN M*	PLAN N	PLAN C*	PLAN F*	F ¹
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	✓
Blood (first three pints each year)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	✓
Medicare Part B deductible										✓	✓	✓
Medicare Part B excess charges				✓							✓	✓
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	✓
Out-of-pocket limit in 2024 ²						\$7,060 ²	\$3,530 ²					

*Indicate Plans being offered by Mutual of Omaha Insurance Company.

¹Plans F and G also have a high deductible option which require first paying a plan deductible \$2,800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

²Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

³Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to \$20 for some office visits and up to a \$50 co-payment for emergency room visits that do not result in an inpatient admission.

MONTHLY PREMIUMS
ZIP CODES: 128-139, 144-149

Attained Age	Policy Form MM20 Plan A	Policy Form MM21 Plan B	Policy Form MM22 Plan C	Policy Form MM23 Plan D	Policy Form MM24 Plan F	Policy Form MM25 Plan G	Policy Form MM30 Plan M
All Ages	262.29	382.69	383.11	376.42	385.62	357.03	393.08

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY PREMIUMS
ZIP CODES: 06390

Attained Age	Policy Form MM20 Plan A	Policy Form MM21 Plan B	Policy Form MM22 Plan C	Policy Form MM23 Plan D	Policy Form MM24 Plan F	Policy Form MM25 Plan G	Policy Form MM30 Plan M
All Ages	271.34	395.88	396.33	389.40	398.91	369.34	406.63

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY PREMIUMS

ZIP CODES: 10910, 10912, 10914-919, 10921-922, 10924-926, 10928, 10930, 10932-933, 10940-941, 10943, 10949-950, 10953, 10958-959, 10963, 10969, 10973, 10975, 10979, 10981, 10985, 10987-988, 10990, 10992, 10996-998, 120-127, 140-143

Attained Age	Policy Form MM20 Plan A	Policy Form MM21 Plan B	Policy Form MM22 Plan C	Policy Form MM23 Plan D	Policy Form MM24 Plan F	Policy Form MM25 Plan G	Policy Form MM30 Plan M
All Ages	277.37	404.68	405.13	398.05	407.78	377.55	415.67

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY PREMIUMS

ZIP CODES: 005, 100-108, 10901, 10911, 10913, 10920, 10923, 10927, 10931, 10951-952, 10954, 10956, 10960, 10962, 10964-965, 10968, 10970, 10974, 10976-977, 10980, 10982-984, 10986, 10989, 10993-995, 110 - 119

Attained Age	Policy Form MM20 Plan A	Policy Form MM21 Plan B	Policy Form MM22 Plan C	Policy Form MM23 Plan D	Policy Form MM24 Plan F	Policy Form MM25 Plan G	Policy Form MM30 Plan M
All Ages	349.72	510.25	510.82	501.89	514.16	476.04	524.11

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

Premium Information

We, Mutual of Omaha, can only raise your premium if we raise the premium for all the policies like yours in the same classification in this state.

Disclosures

Use this outline to compare benefits and premiums among policies.

Read Your Policy Very Carefully

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and the Mutual of Omaha Insurance Company.

Right to Return Policy

If you find that you are not satisfied with your policy, you may return it to Mutual of Omaha Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

Policy Replacement

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice

The policy may not fully cover all of your medical costs. Neither Mutual of Omaha nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

Complete Answers Are Very Important

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan A Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$0	\$1,632 (Part A deductible)
61 st through 90 th day	All but \$408 a day	\$408 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$204 a day	\$0	Up to \$204 a day
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

PLAN A
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$240 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A AND B

Services	Medicare Pays	Plan A Pays	You Pay
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
DURABLE MEDICAL EQUIPMENT			
First \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN B
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan B Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A deductible)	\$0
61 st through 90 th day	All but \$408 a day	\$408 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$204 a day	\$0	Up to \$204 a day
101 st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

PLAN B
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$240 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan B Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A AND B

Services	Medicare Pays	Plan B Pays	You Pay
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
DURABLE MEDICAL EQUIPMENT			
First \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD – Plan C – Medicare first eligible before 2020 only

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan C Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A Deductible)	\$0
61 st through 90 th day	All but \$408 a day	\$408 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$204 a day	Up to \$204 a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

PLAN C

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR – Plan C – Medicare first eligible before 2020 only

*Once you have been billed \$240 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan C Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$240 of Medicare Approved Amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare Approved Amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A AND B

Services	Medicare Pays	Plan C Pays	You Pay
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
DURABLE MEDICAL EQUIPMENT			
First \$240 of Medicare Approved Amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN C

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan C Pays	You Pay
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime Maximum Benefit of \$50,000	20% and amounts over the \$50,000 lifetime Maximum Benefit

**PLAN D
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan D Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A Deductible)	\$0
61 st through 90 th day	All but \$408 a day	\$408 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$204 a day	Up to \$204 a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

PLAN D
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$240 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan D Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A AND B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
DURABLE MEDICAL EQUIPMENT			
First \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN D

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan D Pays	You Pay
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime Maximum Benefit of \$50,000	20% and amounts over the \$50,000 lifetime Maximum Benefit

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD – Plan F – Medicare first eligible before 2020 only

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan F Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A Deductible)	\$0
61 st through 90 th day	All but \$408 a day	\$408 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$204 a day	Up to \$204 a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR – Plan F – Medicare first eligible before 2020 only

*Once you have been billed \$240 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan F Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$240 of Medicare Approved Amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare Approved Amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A AND B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
DURABLE MEDICAL EQUIPMENT			
First \$240 of Medicare Approved Amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan F Pays	You Pay
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime Maximum Benefit of \$50,000	20% and amounts over the \$50,000 lifetime Maximum Benefit

PLAN G
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan G Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A Deductible)	\$0
61 st through 90 th day	All but \$408 a day	\$408 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$204 a day	Up to \$204 a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$240 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan G Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A AND B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
DURABLE MEDICAL EQUIPMENT First \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan G Pays	You Pay
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime Maximum Benefit of \$50,000	20% and amounts over the \$50,000 lifetime Maximum Benefit

PLAN M
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan M Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1,632	\$816 (50% Part A Deductible)	\$816 (50% Part A Deductible)
61 st through 90 th day	All but \$408 a day	\$408 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$204 a day	Up to \$204 a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

PLAN M

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$240 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan M Pays	You Pay
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A AND B

Services	Medicare Pays	Plan M Pays	You Pay
HOME HEALTH CARE – MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
DURABLE MEDICAL EQUIPMENT First \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan M Pays	You Pay
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime Maximum Benefit of \$50,000	20% and amounts over the \$50,000 lifetime Maximum Benefit